Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert Panzarella, MD

Respondent Name
Standard Fire Insurance Company

MFDR Tracking Number
M4-15-1399-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
January 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill in the amount of $500.00 sent via fax #877-749-0075.

09/18/2014 Received denial stating Account # required. All information was already included on initial bill. Contacted Travelers by phone and was told that they would send the bill back through.

Received payment of $350.00 with a $150.00 reduction. Explanation of reduction was 'Reimbursement is Based on Applicable Reimbursement Fee Schedule'

11/12/2014 Bill resubmitted for reconsideration and denied again 12/15/2014.

We feel that our charges are in accordance with TDI/DWC fee schedule guidelines."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for a Designated Doctor evaluation. The Provider performed a Maximum Medical Improvement evaluation and submitted billing in the amount of $500.00 for 1 unit of service. The Carrier reviewed the billing and Designated Doctor report and issued reimbursement in the amount of $350.00. After submitting a request for reconsideration, the Provider filed this Request for Medical Fee Dispute Resolution.

The Provider contends they are entitled to an additional $150.00 for the evaluation in dispute. The Carrier disagrees that additional reimbursement is due in the amount of $150.00. The Maximum Allowable Reimbursement for this Designated Doctor evaluation was calculated based on the Maximum Medical Improvement evaluation of $350.00. No additional reimbursement was allowable for the impairment rating as the rating was not calculated by either the DRE model or the Range of Motion model. Additionally, no testing was done to assess the impairment rating, so no reimbursement is due. As no musculoskeletal body areas were assessed and no non-musculoskeletal body areas were tested, no additional reimbursement is due under Rule 134.202(e)(6)(iii) or (iv)."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2014	Designated Doctor Examination (MMI/IR)	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for approving or denying medical bills.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12 – not defined as required in 28 Texas Administrative Code §133.240
   - 863 – Reimbursement is based on the applicable reimbursement fee schedule
   - 193 – not defined as required in 28 Texas Administrative Code §133.240
   - 1115 – Generic denial

Issues

1. What is the correct rule for addressing the disputed services?
2. What is the correct MAR for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier refers to Rule 134.202(e)(6)(iii) or (iv) in their position statement. 28 Texas Administrative Code §134.204 (a) states, in relevant part, "(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008. (3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies." Review of the submitted documentation finds that the dispute involves a Designated Doctor Examination performed on date of service August 20, 2014. Therefore, the correct rule for addressing the disputed services is §134.204.
2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this part of the examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4)(D), "(iv) When there is no test to determine an IR for a non-musculoskeletal condition: (I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category. (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings. (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph. (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150." The narrative submitted by the requestor states, "Using the Guides, page 162, Table 8, the patient would be in Class 2. He has … FVC at 60% of predicted and that puts him in Class 2. This is mild impairment of the whole person. He would be at the low end of the impairment rating range, so his IR would be 10%. WP=10%" Therefore, the correct MAR for this part of the examination is $150.00.
3. The total allowable for the disputed services is $500.00. The insurance carrier paid $350.00. Therefore, an additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	April 2, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.